1-1 By: Anderson of Dallas, et al. H.B. No. 490
1-2 (Senate Sponsor - Kolkhorst)
1-3 (In the Senate - Received from the House April 26, 2017;
1-4 May 5, 2017, read first time and referred to Committee on Business
1-5 & Commerce; May 17, 2017, reported favorably by the following vote:
1-6 Yeas 9, Nays 0; May 17, 2017, sent to printer.)

1-7 COMMITTEE VOTE

1-8		Yea	Nay	Absent	PNV
1-9	Hancock	X			
1-10	Creighton	X			
1-11	Campbell	X			
1-12	Estes	X			
1-13	Nichols	X			
1-14	Schwertner	X			
1-15	Taylor of Galveston	X			
1-16	Whitmire	X			
1-17	Zaffirini	X			

1-18 A BILL TO BE ENTITLED
1-19 AN ACT

1-20 relating to health benefit plan coverage of hearing aids and
1-21 cochlear implants for certain individuals.
1-22 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-23 SECTION 1. Chapter 1367, Insurance Code, is amended by
1-24 adding Subchapter F to read as follows:
1-25 SUBCHAPTER F. HEARING AIDS AND COCHLEAR IMPLANTS
1-26 Sec. 1367.251. APPLICABILITY OF SUBCHAPTER. (a) This
1-27 subchapter applies only to a health benefit plan, including a small
1-28 employer health benefit plan written under Chapter 1501 or coverage
1-29 provided through a health group cooperative under Subchapter B of
1-30 that chapter, that provides benefits for medical or surgical
1-31 expenses incurred as a result of a health condition, accident, or
1-32 sickness, including an individual, group, blanket, or franchise
1-33 insurance policy or insurance agreement, a group hospital service
1-34 contract, or an individual or group evidence of coverage or similar
1-35 coverage document that is offered by:
1-36 (1) an insurance company;
1-37 (2) a group hospital service corporation operating
1-38 under Chapter 842;
1-39 (3) a fraternal benefit society operating under
1-40 Chapter 885;
1-41 (4) a Lloyd's plan operating under Chapter 941;
1-42 (5) a stipulated premium insurance company operating
1-43 under Chapter 884;
1-44 (6) a reciprocal exchange operating under Chapter 942;
1-45 (7) a health maintenance organization operating under
1-46 Chapter 843;
1-47 (8) a multiple employer welfare arrangement that holds
1-48 a certificate of authority under Chapter 846; or
1-49 (9) an approved nonprofit health corporation that
1-50 holds a certificate of authority under Chapter 844.
1-51 (b) This subchapter applies to coverage under a group health
1-52 benefit plan described by Subsection (a) provided to a resident of
1-53 this state, regardless of whether the group policy, agreement, or
1-54 contract is delivered, issued for delivery, or renewed within or
1-55 outside this state.
1-56 (c) This subchapter applies to a self-funded health benefit
1-57 plan sponsored by a professional employer organization under
1-58 Chapter 91, Labor Code.
1-59 (d) Notwithstanding Section 22.409, Business Organizations
1-60 Code, or any other law, this subchapter applies to health benefits
1-61 provided by or through a church benefits board under Subchapter I,

2-1 Chapter 22, Business Organizations Code.
2-2 (e) Notwithstanding Section 75.104, Health and Safety Code,
2-3 or any other law, this subchapter applies to a regional or local
2-4 health care program operated under that section.
2-5 (f) Notwithstanding any other law, a standard health
2-6 benefit plan provided under Chapter 1507 must provide the coverage
2-7 required by this subchapter.
2-8 (g) Notwithstanding any provision in Chapter 1551, 1575,
2-9 1579, or 1601 or any other law, this subchapter applies to:
2-10 (1) a basic coverage plan under Chapter 1551;
2-11 (2) a basic plan under Chapter 1575;
2-12 (3) a primary care coverage plan under Chapter 1579;
2-13 and
2-14 (4) basic coverage under Chapter 1601.
2-15 Sec. 1367.252. EXCEPTION. This subchapter does not apply
2-16 to:
2-17 (1) a plan that provides coverage:
2-18 (A) for wages or payments in lieu of wages for a
2-19 period during which an employee is absent from work because of
2-20 sickness or injury;
2-21 (B) as a supplement to a liability insurance
2-22 policy;
2-23 (C) for credit insurance;
2-24 (D) only for dental or vision care;
2-25 (E) only for hospital expenses; or
2-26 (F) only for indemnity for hospital confinement;
2-27 (2) a Medicare supplemental policy as defined by
2-28 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
2-29 (3) a workers' compensation insurance policy;
2-30 (4) medical payment insurance coverage provided under
2-31 a motor vehicle insurance policy;
2-32 (5) a long-term care policy, including a nursing home
2-33 fixed indemnity policy, unless the commissioner determines that the
2-34 policy provides benefit coverage so comprehensive that the policy
2-35 is a health benefit plan as described by Section 1367.251; or
2-36 (6) the state Medicaid program, including the Medicaid
2-37 managed care program operated under Chapter 533, Government Code.
2-38 Sec. 1367.253. COVERAGE REQUIRED. (a) A health benefit
2-39 plan must provide coverage for the cost of a medically necessary
2-40 hearing aid or cochlear implant and related services and supplies
2-41 for a covered individual who is 18 years of age or younger.
2-42 (b) Coverage required under this section:
2-43 (1) must include:
2-44 (A) fitting and dispensing services and the
2-45 provision of ear molds as necessary to maintain optimal fit of
2-46 hearing aids;
2-47 (B) any treatment related to hearing aids and
2-48 cochlear implants, including coverage for habilitation and
2-49 rehabilitation as necessary for educational gain; and
2-50 (C) for a cochlear implant, an external speech
2-51 processor and controller with necessary components replacement
2-52 every three years; and
2-53 (2) is limited to:
2-54 (A) one hearing aid in each ear every three
2-55 years; and
2-56 (B) one cochlear implant in each ear with
2-57 internal replacement as medically or audiologically necessary.
2-58 (c) Except as provided by Subsections (b) and (d), coverage
2-59 required under this section:
2-60 (1) may not be less favorable than coverage for
2-61 physical illness generally under the plan; and
2-62 (2) must be subject to durational limits and
2-63 coinsurance factors no less favorable than coverage provided for
2-64 physical illness generally under the plan.
2-65 (d) Coverage required under this section is subject to any
2-66 provision that applies generally to coverage provided for durable
2-67 medical equipment benefits under the plan, including a provision
2-68 relating to deductibles, coinsurance, or prior authorization.
2-69 (e) This section does not apply to a qualified health plan

3-1 defined by 45 C.F.R. Section 155.20 if a determination is made under
3-2 45 C.F.R. Section 155.170 that:
3-3 (1) this subchapter requires the plan to offer
3-4 benefits in addition to the essential health benefits required
3-5 under 42 U.S.C. Section 18022(b); and
3-6 (2) this state must make payments to defray the cost of
3-7 the additional benefits mandated by this subchapter.
3-8 SECTION 2. The change in law made by this Act applies only
3-9 to a health benefit plan delivered, issued for delivery, or renewed
3-10 on or after January 1, 2018. A health benefit plan delivered,
3-11 issued for delivery, or renewed before January 1, 2018, is governed
3-12 by the law as it existed immediately before the effective date of
3-13 this Act, and that law is continued in effect for that purpose.
3-14 SECTION 3. This Act takes effect September 1, 2017.

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